Department of Medical Assistance Services
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http://www.dmas.virginia.gov

MEDICAID MEMO

TO: Medicaid Long-Term Services and Supports (LTSS) Screening Entities (Community-Based and Hospital Teams) and LTSS Providers [Commonwealth Coordinated Care Plus (CCC Plus) Waiver Providers, Nursing Facilities (NF), CCC Plus Health Plans], Fee-for-Services (FFS) Providers, Hospitals; and Medicaid Managed Care Organizations

FROM: Jennifer S. Lee, M.D., Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 9/26/18

SUBJECT: Final Regulations Pertaining to Medicaid Long-Term Services and Support Screenings – Effective November 1, 2018

The purpose of this memorandum is to inform screening entities for Medicaid-funded Long-Term Services and Supports (LTSS) of the release of final screening regulations, effective November 1, 2018.

Summary of Changes to Medicaid LTSS Screening Regulations

The regulations have added new requirements and clarified existing requirements for accepting, managing, and completing requests and referrals for screenings for long-term services and supports, using the electronic Preadmission Screening (ePAS) system, and established competency and testing requirements for screeners.

1. **The following sections have been added**:
   12VAC30-60-301. Definitions.

   A definition section has been added in order to clarify use of terminology in 12VAC30-60-302 through 12VAC30-60-315.

   Items such as "Activities of Daily Living", "At risk", "Choice", "Community-Based Team", "Face to Face", "Hospital Team", "Request for Screening", and "Residence" have been defined.

   12VAC30-60-302. Introduction; access to Medicaid-funded long-term services and supports.

This section outlines locations where Medicaid LTSS may be provided, who is authorized to conduct screening to authorize LTSS pursuant to § 32.1-330 of the Code of Virginia, and outlines the Special Circumstance under which a screening may be exempted.

The section clarifies that individuals must be evaluated for functional capacity, medical or nursing need **and** risk of institutional placement within 30 days. It clarifies that individuals do not need to be determined financially eligible for Medicaid prior to a screening for LTSS.

Special circumstances that exclude individuals from the requirement to have a screening include:

- private pay and those individuals who will not become financially eligible for Medicaid within six months of admission to a nursing facility;
- out-of-state transfers to instate nursing facilities;
- military or veteran hospitals directly admitting individuals to nursing facilities;
- residents of state owned or operated facilities operated by the Department of Behavioral Health and Developmental Disabilities who are admitted directly to a nursing facility; and,
- approval for enrollment for hospice services.

12VAC30-60-304. Requests for screenings for adults and children living in the community and adults and children in hospitals.

Provides guidance to screeners regarding referrals and requests for screening, and identifies the required time for response to requests and the completion and submission of a screening package. Community-based teams should complete the screening within 30 calendar days of request, and hospitals should complete the screening prior to discharge. All screenings shall be submitted via e-PAS or DMAS approved electronic system within 30 days of the screening request.

Requests for screening shall be accepted from any of the following: the individual, the individual's representative (or legal guardian), physician, adult protective services worker (adults), child protective services worker (children), or managed care organization care coordinator.

Screenings in hospitals occur upon request for adults and children who are inpatients.

12VAC30-60-305. Screenings in the community and hospitals for Medicaid-funded long-term services and supports.

This section outlines community and hospital screening process for adults and children.

The section outlines eligible individuals' choice in relation to services and screeners must document this choice on the DMAS-97 Individual Choice form.

This section also specifies that individuals choosing nursing facility services must be evaluated for evidence of possible mental illness, intellectual disability, or related condition (known as a Level I identification process) and Level II evaluation (if applicable) and document the results on the DMAS-95.

Clarification is also provided that all individuals denied LTSS shall be notified in writing and provided appeal rights.

12VAC30-60-306. Submission of screenings.

This section lists the forms that are part of the screening process and clarifies that the forms are submitted electronically to DMAS via approved electronic submission portals.

12VAC30-60-308. NF admission and level of care determination requirements.

Prior to an individual's admission to a nursing facility, the nursing facility shall review the completed screening packet to ensure nursing facility criteria have been met. The nursing facility shall not accept hand-written forms as proof that admission criteria have been met.

12VAC30-60-310. Competency training and testing requirements.

After June 30, 2019, each person performing screening or providing final approval of screenings shall complete screening competency training and pass with a score of at least 80 percent.

12VAC30-60-313. Individuals determined to not meet criteria for Medicaid-funded long-term services and supports.

This section provides information concerning situations when individuals do not meet criteria for Medicaid-funded long-term services and supports.

12VAC30-60-315. Ongoing evaluations for individuals receiving Medicaid-funded long-term services and supports.

This section clarifies that individuals must be periodically assessed to ensure the individual continues to meet nursing facility level of care criteria. For those enrolled in home and community-based services individuals shall be evaluated via the level of care review. For individuals admitted to a nursing facility the MDS shall be used to monitor level of care criteria.

1. **Amended section**:
   12VAC30-60-303. Preadmission screening criteria for Medicaid-funded long-term services and supports.

   This section clarifies that nursing facility level of care criteria is not limited to functional capacity, and the criteria includes medical and nursing needs, as well as being at-risk for

nursing facility placement. All three criteria areas must be assessed during the initial determination of need for LTSS.

2. **Repealed sections:**
   12VAC30-60-300. Nursing Facility Criteria. (Incorporated into 12VAC30-60 sections 302, 303, 304, 305, and 308.)

   12VAC30-60-307. Summary of screening nursing facility criteria. (Incorporated into 12 VAC 30-60 sections 303 and 313)

   12VAC30-60-312. Evaluation to determine eligibility for Medicaid payment of nursing facility or home and community-based. (Incorporated into 12 VAC 30-60-305.)

This action does not change any of the existing criteria that derive from the Uniform Assessment Instrument, or to any other forms associated with the screening process.

MAGELLAN BEHAVIORAL HEALTH OF VIRGINIA (Behavioral Health Services Administrator)

Providers of behavioral health services may check member eligibility, claims status, check status, service limits, and service authorizations by visiting www.MagellanHealth.com/Provider. If you have any questions regarding behavioral health services, service authorization, or enrollment and credentialing as a Medicaid behavioral health service provider please contact Magellan Behavioral Health of Virginia toll free at 1-800-424-4046 or by visiting www.magellanofvirginia.com or submitting questions to VAProviderQuestions@MagellanHealth.com.

MANAGED CARE PROGRAMS

Most Medicaid individuals are enrolled in one of the Department's managed care programs: Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the individual's managed care plan/PACE provider directly.

Contact information for managed care plans can be found on the DMAS website for each program as follows:

- Medallion 4.0:
  http://www.dmas.virginia.gov/#/med4
- Commonwealth Coordinated Care Plus (CCC Plus):
  http://www.dmas.virginia.gov/#/cccplus
- Program of All-Inclusive Care for the Elderly (PACE)
  http://www.dmas.virginia.gov/#/longtermprograms

COMMONWEALTH COORDINATED CARE PLUS

Commonwealth Coordinated Care Plus is a required managed long term services and supports program for individuals who are either 65 or older or meet eligibility requirements due to a disability. The program integrates medical, behavioral health, and long term services and supports into one program and provides

care coordination for members. The goal of this coordinated delivery system is to improve access, quality and efficiency. Please visit the website at: http://www.dmas.virginia.gov/#/cccplus

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

KEPRO PROVIDER PORTAL

Providers may access service authorization information including status via KEPRO's Provider Portal at https://providerportal.kepro.com/Account/Login.aspx?ReturnUrl=%2f

HELPLINE

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

TO ALL MEDICAID PROVIDERS: PROVIDER APPEAL REQUEST FORM NOW AVAILABLE

There is now a form available on the DMAS website to assist providers in filing an appeal with the DMAS Appeals Division. The link to the page is http://www.dmas.virginia.gov/#/appealsresources and the form can be accessed from there by clicking on, "Provider Appeal Request Form." The form is in PDF format and has fillable fields. It can either be filled out online and then printed or downloaded and saved to your business computer. It is designed to save you time and money by assisting you in supplying all of the necessary information to identify your area of concern and the basic facts associated with that concern. Once you complete the form, you can simply print it and attach any supporting documentation you wish, and send to the Appeals Division by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission supported by the Agency.

PROVIDERS: NEW MEDICARE CARDS ARE COMING

CMS is removing Social Security Numbers from Medicare cards to help fight identity theft and safeguard taxpayer dollars. In previous messages, CMS has stated that you must be ready by April 2018 for the change from the Social Security Number based Health Insurance Claim Number to the randomly generated Medicare Beneficiary Identifier (the new Medicare number). Up to now, CMS has referred to this work as the Social Security Number Removal Initiative (SSNRI). Moving forward, CMS will refer to this project as the New Medicare Card.

To help you find information quickly, CMS designed a new homepage linking you to the latest details, including how to talk to your Medicare patients about the new Medicare Card. Bookmark the New

Medicare Card homepage and Provider webpage, and visit often, so you have the information you need to be ready by April 1st.

Providers (which includes fee for service, Medicaid Managed Care Organizations, and Commonwealth Coordinated Care Plus) may share the following information with members:

MEMBERS: NEW MEDICARE CARDS ARE COMING

Medicare will mail new Medicare cards between April 2018 and April 2019. Your new card will have a new Medicare Number that is unique to you, instead of your Social Security Number. This will help to protect your identity.

Additional information is available at the following link:
https://www.medicare.gov/forms-help-and-resources/your-medicare-card.html